Agreement Number
0616898

SERVICE PROVIDER AGREEMENT

Nebraska Department of Health and Human Services

DHHS

Section I

Check Appropriate Box and Write Provider Number

☒ Agency FID **470825758** ☐ Individual Provider Social Security Number _____

Name FID Issued To: **PRIME CONSULTANTS**

Section II

Provider Name: (First) (Middle) (Last) Birthdate:

GOODWILL MEDICAL TRANSPORTATION

Provider Street Address, City, State & Zip: **15226 Corby Omaha, Ne. 68116**

Mailing Address if Different from Location: **PO Box 34547 Omaha Ne. 68134**

Business Telephone: **402-932-1550** Home Telephone: _____

Appropriate Licensure: **YES PSC**

Location of Service Provision if Different than Above: **designated locations authorized by case managers**

Par. 1 This Agreement between the Nebraska Department of Health and Human Services (hereinafter the Department) and **Goodwill Transportation**, a service provider, governs the provision of the following service(s) checked below as defined in the Department of Health and Human Services Program Manual, Nebraska Administrative Code (NAC) Titles 404, 465, 471, 473, 474 and 480. Appropriate checklist(s) marked "Provider Addendum (name of service)" and other appropriate additions to the Agreement marked "Attachment 9A, B or C)" for contracted service is/are attached and by this reference are made part of this Agreement as if included in the contract word for word and the provider agrees to abide by all regulations as outlined in the attachment(s).

Par. 2 Agreement Effective Date from **NOVEMBER 15, 2008** through **NOVEMBER 14, 2009**

Par. 3 Service(s) to be provided. (See corresponding service addendum.) DD = Developmental Disabilities

- ☐ Adult Day Care
- ☐ Adult Day Health
- ☐ Assisted Living
- ☐ Assisted Technology–DD
- ☐ Child Care
- ☐ Community Living & Day Support–DD
- ☐ Congregate Meals
- ☐ Family Support
- ☐ Habilitative Day Care
- ☐ Homemaker
- ☐ Homemaker–DD
- ☐ Home Care/Chore
- ☐ Home Delivered Meals
- ☐ Home Modification–DD
- ☐ Independence Skills Man.
- ☐ Nutrition Service
- ☐ PERS
- ☐ PERS–DD
- ☐ Personal Assistance–Medicaid
- ☐ Respite Care
- ☒ Transportation
- ☐ Vehicle Modifications–DD

Section III

Terms of Agreement

Par. 1 If the provider violates or breaches any of the provisions of this Agreement, then this Agreement may be terminated immediately, at the election of the Department. If there are any damages arising from such violation or breach, legal remedies may be pursued to recover such damages. Any money due to the provider, which accrued prior to such violation or breach, may be offset against the damages.

Par. 2 Under the terms of this Agreement:

1. Staff will determine eligibility for services and authorize appropriate services for the individuals.
2. Staff will notify provider if the service(s) being provided for a specific client is to be terminated or changed before the end of the authorization period.
3. The Department will honor claims and make payments for services that were authorized and provided in accordance with the Department's policies and standards.

Par. 3 This Agreement may be terminated by either party at any time by giving at least thirty days advance written notice to the other party to allow for arrangement of alternate service provision for clients. The notice requirement may be waived in case of emergencies such as illness, death, injury or fire. Only such payments as have already accrued for services rendered prior to the effective date of termination shall be made to the provider upon such voluntary termination.

Par. 4 Subcontracting by an individual provider is not allowed under this Agreement.

Par. 5 Service(s) will be provided using the following unit rate(s) within the maximum number of units authorized by the service area staff on a case-by-case basis.

Service Code	Service	Maximum	Units
See Attachment A			

Attach documentation of basic or specialized status of Medicaid Personal Assistant.

Par. 6 The above terms of this Agreement, Paragraphs 1 through 5 may be renegotiated upon agreement of both parties. The party requesting a change in the above terms must notify the other party at least sixty (60) days before the date the proposed change is to be implemented, except for rate changes due to minimum wage changes, rates regulated by governmental agencies or other changes required by law.

Section IV

General Provider Standards

By signing this Agreement, the service provider agrees to:

1. Follow all applicable Nebraska Department of Health and Human Services' policies and procedures (Nebraska Administrative Code Titles 404, 465, 471, 473, 474 and 480).
2. Bill only for services which are authorized and actually provided.
3. Submit billing documents after service is provided and within 90 days.
4. Accept payment as payment in full (payment from DHHS plus the client's obligation) and assure that the rate negotiated or charged does not exceed the amount charged to private payers.
5. Not provide services if s/he is the legally responsible relative (i.e., spouse of client or parent of minor child who is a client).
6. Not discriminate against any employee, applicant for employment or program participant or applicant because of race, age, color, religion, sex, handicap or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60.
7. Retain financial and statistical records for six years from date of service provision to support and document all claims.
8. Allow federal, state or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20 – 74.24; and 42 CFR 431.107. Inspections, reviews and audits may be conducted on site.
9. Keep current any state or local license/certification required for service provision.
10. Provide services as an independent contractor, if the provider is an individual, recognizing that s/he is not an employee of the Department or of the State.
11. Agree and assure that any false claims (including claims submitted electronically), statement, documents or concealment of material fact may be prosecuted under applicable state or federal laws (42 CFR 455.18).
12. Respect every client's right to confidentiality and safeguard confidential information.
13. Understand and accept responsibility for the client's safety and property.
14. Not transfer this Agreement to any other entity or person.
15. Operate a drug free workplace.
16. Not use any federal funds received to influence agency or congressional staff.
17. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect and/or the sex offender registries.
18. Allow Central Registry checks on himself/herself, family member if appropriate, or if an agency, agree to allow Department of Health and Human Services' staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect and law violations are in place.
19. Have the knowledge, experience and/or skills necessary to perform the task(s).
20. Report changes to appropriate Department staff (e.g., no longer able/willing to provide service, changes in client function).
21. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate Department staff.

I certify that I have read and understand the standards as stated and referenced above and agree to comply with all the terms of this Agreement.

Section V

Provider/Agency Representative — Date: 10/29/08

Parent or Legal Guardian Signature (if required) — Date

William Grayson — Date: 10-29-08

Signature of Authorized Representative – Nebraska Department of Health and Human Services — Date

ATTACHMENT A
PRIME CONSULTANTS dba
GOODWILL TRANSPORTATION, INC.

RATE INCREASE EFFECTIVE JULY 1, 2008

DIRECTOR - MR. PETER NGANTAR

N-FOCUS NUMBER 86758652

15226 CORBY
OMAHA, NE. 68116
T 402 932 1550
F 402 932 1551

SERVICE	PROGRAM	SERVICE	MAXIMUM RATE	UNIT
7787	SSAD,SSCF,APS, A&D	TRANSPORTATION COMMERCIAL LOCAL	VAN $15.78 WHEELCHAIR $38.24	ONE-WAY TRIP ONE-WAY TRIP
2979	SSAD,SCF,APS, A&D	TRANSPORTATION COMMERCIAL LOCAL MEDICAL	VAN $15.78 WHEELCHAIR $38.24	ONE-WAY TRIP ONE-WAY TRIP
5581	SSCF,AD,CFS	ESCORT	VAN $15.78 WHEELCHAIR $38.24	ONE-WAY TRIP ONE-WAY TRIP
9989	SSAD, SSCF, APS AD	ESCORT MEDICAL	VAN $15.78 WHEELCHAIR $38.24	ONE-WAY TRIP ONE-WAY TRIP

PRESENTLY OPERATING IN OMAHA METRO ONLY

AGENCY IS AVAILABLE FOR SAME DAY TRANSPORTATION AND OPERATES 24.7.

BEFORE THE NEBRASKA PUBLIC SERVICE COMMISSION

In the Matter of the Prescription of Reasonable Rates and Charges for Motor Carriers Passengers and Property for Hire subject to the Provisions of Neb. Rev. Stat. (Reissue 1996), Chapter 75, Articles 1 and 3.	) APPLICATION NO. BR-285)) GRANTED)) ENTERED: August 12, 2003)	

BY THE COMMISSION:

OPINION AND FINDINGS

On April 15, 203, Prime Consultants, Inc., dba Goodwill Medical Transportation, Inc., Omaha, Nebraska filed an application for authority to amend its van rates and to establish weekend and after 5:00 p.m. rates for its use as follows:

Description (See Note)	Current Rates	Proposed Rates
I. Standard Rates:		
A. Ambulatory passenger		
1. One-way	$13.00	$18.00
2. Round-trip	26.00	36.00
B. Wheelchair passenger		
1. One-way	$30.00	$38.00
2. Round-trip	60.00	76.00
II. Weekend and after 5:00 p.m. rates (New)		
A. Ambulatory passenger		
1. One-way		$20.00
2. Round-trip		40.00
B. Wheelchair passenger		
1. One-way		$40.00
2. Round-trip		80.00

Note: Rates are per person

Notice of the application was published in The Daily Record. Omaha, Nebraska, on April 17, 2003, pursuant to the Commission rules. There were no protests filed.

The Applicant is a certificated common carrier which holds Certificate B-1555. The certificate authorizes the transportation of passengers in open class service by passenger van between points in Cass, Douglas, Sarpy, and Washington counties over irregular routes.

According to the Applicant, the proposed rate increases are necessary to cover the increasing cost of insurance, fuel, vehicle maintenance, driver compensation, and other operating expenses. The increase requested for weekend and after 5:00 p.m. service is deemed necessary to provide adequate compensation for the drivers. The retention of good drivers is important to provide a professional, courteous service to our clientele.

Applicant has been in operation since October 2001. In support of the application, the Applicant provided financial data for its first full year of operation. The financial data reveals gross income of $96,407; however, after expenses, the balance at the end of the year was $3,532. Applicant is operating three vans. The proposed rates are competitive with other van operators operating in the Omaha metropolitan area.

Upon consideration of the application and being fully advised in the premises, the Commission is of the opinion and finds that the application should be granted.

ORDER

IT IS, THEREFORE, ORDERED by the Nebraska Public Service Commission that Prime Consultants, Inc., dba Goodwill Medical Transportation, Inc., Omaha, Nebraska, be, and it is hereby, authorized to amend its van rates and to establish weekend and after 5:00 p.m. rates for its use as follows:

Description (See Note)	Rates
I. Standard Rates:	
A. Ambulatory passenger	
1. One-way	$18.00
2. Round-trip	36.00
B. Wheelchair passenger	
1. One-way	$38.00
2. Round-trip	76.00
II. Weekend and after 5:00 p.m. rates (New)	
C. Ambulatory passenger	
1. One-way	$20.00
2. Round-trip	40.00
D. Wheelchair passenger	
1. One-way	$40.00
2. Round-trip	80.00

Note: Rates are per person.

Rmc

Form **W-9**
(Rev. October 2004)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

DEC 2 0 2004

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as reported on your income tax return)
PRIME CONSULTANTS, INC dba Goodwill Medical Transportation

Business name, if different from above
SAME AS ABOVE

Check appropriate box: ☐ Individual/ Sole proprietor ☒ Corporation ☐ Partnership ☐ Other ▶ ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)
3707 N 105 P.O Box 34547

Requester's name and address (optional)

City, state, and ZIP code
Omaha, NE 68134

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
			–					

or

Employer identification number
4	7	0	8	2	5	7	5	8

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ [signature] Date ▶ 12/17/04

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- an individual who is a citizen or resident of the United States,
- a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- any estate (other than a foreign estate) or trust. See Regulation section 301.7701-6(a) for additional information.

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.